MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Thursday, April 22, 2004
10:09 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
NANCY-ANN DePARLE
DAVID F. DURENBERGER
ALLEN FEEZOR
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM:

Characteristics of independent diagnostic testing facilities and ambulatory surgical centers
-- Ariel Winter

MR. WINTER: As Glenn said, I'll be talking about two types of facilities that focus on different kinds of outpatient services. One you've heard about before and that's ASCs. The other type we'll be discussing for the first time and that's independent diagnostic testing facilities or IDTFs. We'll be looking at IDTFs because they're a growing provider of imaging services and are an example of how CMS has attempted to regulate the provision of these services.

So here's the overview of the presentation. First I'll explain what IDTFs are and what services they provide. We'll look at the growth of spending for IDTF services, raise some policy questions and think about next steps. Then we'll turn our attention to a couple of ASC related issues. We'll continue our analysis of the extent to which ASCs specialize in certain services, which will be useful as we think about the development of a new ASC payment system. Finally, we'll discuss the characteristics of markets in which ASCs are located.

A facility that provides diagnostic service that is independent of a hospital and physician office must enroll with Medicare as an IDTF. Later on I'll explain the details of this definition. Medicare spent about $740 million for IDTF services in 2002. This includes both program spending and beneficiary cost-sharing. Imaging procedures accounted for about 85 percent of all IDTF spending, or $630 million. The remainder was primarily for tests, such as electrocardiograms and cardiac stress tests.

To put this in perspective, total Medicare spending for imaging services paid under the physician fee schedule was about $8 billion in 2002. So IDTFs accounted for about 8 percent of imaging spending.

This chart shows the distribution of IDTF spending by type of service. MRI was the largest category at 41 percent, followed by tests, cardiac catheterization and related imaging, other echography, which is ultrasound, and CT, or computed tomography. IDTFs are paid under the physician fee schedule at the same rates as physician offices. Under the fee schedule, Medicare makes separate payments for the technical component and professional component of a test unless both components are furnished by the same provider. The technical component covers the cost of the equipment and non-physician staff while the professional component covers the physician work involved.

As you've heard before in other contexts, spending on imaging services paid under the physician fee schedule has been growing rapidly. It increased by 27 percent between 2000 and 2002. Spending for the portion of these services provided in IDTFs grew more than three times as fast during this period. The fastest growth in IDTF services occurred among cardiac

catheterization and related imaging, CT, and nuclear medicine. We identified 2,400 IDTF entities in 2002 using 2002 Medicare claims. This represented a 35 percent increase from 2000. Each entity may have more than one location which may be fixed or mobile, such as a trailer. We identified 3,600 separate locations in 2002 which is an average of almost 1.5 per entity.

We also looked at what kind of services high-volume IDTFs provided. We wanted to learn what share of these facilities specialize in a single type of procedure. That is, they derived at least 90 percent of their Medicare revenue from a single procedure category. We found that only 30 percent specialize in one category of services, which was mostly MRI or tests.

We also plan to look at the geographic distribution of IDTFs and the characteristics of markets in which they're located.

The rapid growth of IDTF spending raises the following questions. Why did CMS create this category and how does CMS distinguish IDTFs from physician offices? What rules does CMS apply to IDTFs, and how are they monitored? Medicare created the IDTF category for freestanding diagnostic centers in 1998. Previously these entities were largely unregulated by CMS or the states. The Office of Inspector General and CMS had found evidence of fraudulent behavior and inappropriate use of services by freestanding centers. There were also safety and quality concerns. Thus, CMS developed the IDTF category and its rules to address these problems.

To elaborate on the definition I gave you earlier, a diagnostic center is considered to be independent of a hospital and physician office and thus required to enroll as an IDTF if it is not a physician practice that is owned by one or more physicians or a hospital, if it primarily bills for diagnostic tests rather than other physician services such as evaluation and management, and if it provides diagnostic tests primarily to patients whose conditions are not treated by physicians in the practice. In other words, it's sole purpose is to provide diagnostic tests, services to patients who conditions are treated elsewhere.

A radiology practice is different in nature than other physician practices because it primarily performs and interprets radiological tests but does not treat patients' underlying conditions. Thus, CMS applies different criteria when deciding whether a radiology practice is a physician office. The radiology practice is exempt from enrolling as an IDTF if the practice is owned by a radiologist or hospital, the radiologists provide test interpretations at the location where the diagnostic tests are performed, and the practice primarily provides professional services of the radiologist.

Some diagnostic services are exempt from the IDTF rules. These are mammography, which is regulated by the FDA, certain tests furnished by audiologists, physical therapists, and clinical psychologists which do not require physician supervision, and clinical laboratory tests which are regulated by the Clinical Laboratory Improvement Amendments.

IDTFs are subject to the following rules which do not apply to physician offices that furnish diagnostic tests. They're

required to go through an enrollment process with the carrier in their your area. They must have at least one supervising physician who oversees the quality of the testing, the operation and calibration of the equipment, and the qualifications of the non-physician staff. The non-physician staff must be licensed by the state or certified by a national credentialing body. All procedures performed by an IDTF must be ordered in writing by the beneficiary's treating physician. And finally, the list of procedures they wish to provide must be approved by their carriers.

Before enrolling IDTFs in Medicare, the carriers must verify through document review and a site visit that the IDTF actually exists, that it meets the requirements that we mentioned on the previous slide, that the equipment it uses is properly maintained and calibrated. However, CMS does not specify the standards carriers should use in evaluating the equipment.

IDTFs are not subject to ongoing monitoring such as repeat site visits except under certain circumstances. The OIG plans to review whether services provided by IDTFs are medically necessary, there is adequate physician supervision, and non-physician are properly licensed or certified. The IG's concern underscores why we're interested in how these facilities are monitored.

So where do we go next, both with regards to IDTFs and on the broader topic of imaging services? Presumably our overarching goal is to control growth in the cost and use of these services while at the same time ensuring access to appropriate high-quality care. This could be a difficult balance to achieve between these two objectives.

So what tools can we use to accomplish this goal? These could include some of the methods that CMS uses to regulate IDTFs as well as some of the private purchasing strategies we heard about earlier. We could also think about incorporating some of the methods that the federal government uses to regulate mammography and laboratory services.

Then finally, in what settings should we apply these tools? Should they be limited to freestanding facilities like IDTFs, or also apply to physician offices? At the end of the presentation we'd like to get your feedback on these questions.

Now I'll move on to the ASC topics. For our March report we tried to characterize ASCs by what services they provide. We used 2002 claims data to estimate the proportion of single specialty and multispecialty ASCs certified by Medicare. This is an important issue changes to the ASC payment system may affect single specialty and multispecialty facilities differently. For example, a large reduction in rates for eye procedures could have a bigger impact on an ophthalmology ASC than an ASC that performs a variety of procedures. It's also relevant because facilities that specialize in one type of procedure may be more efficient and thus have a different cost structure than a multispecialty facility.

Since the March report we started to track changes in the mix of ASCs over time and we'd like to share our results with you. I just briefly want to review our methodology. We selected

high-volume ASCs, those that submitted at least 1,000 claims, so that we'd have an adequate sample size to look at, and we looked at their share of Medicare revenue related to each physician specialty. We define a single specialty ASC as one with at least 90 percent of revenue related to one physician specialty. The others we classified as multispecialty.

Using this threshold we found that about half of ASCs are single specialty, which is consistent with what an industry survey has found. In the future we may change our definition to one based on the type of procedures that ASC's provide rather than the specialty of the physician providing them. This would be more consistent with how we plan to categorize specialty hospitals as you'll hear about tomorrow.

So using 2000 data we identified 750 high-volume Medicare-certified ASCs, and we found that 56 percent were single specialty, mostly ophthalmology or gastroenterology. By 2002 the number of high-volume ASCs increased to over 1,200. While the number of single specialty ASCs increased, they declined as a share of all high-volume ASCs to 48 percent. This decline was driven by a steep drop in the share of ophthalmology ASCs from 37 to 27 percent. During the same period Medicare payments to ASCs for eye procedures did not increase as fast as payments for all procedures.

In previous MedPAC reports we've noted that ASCs tend to be concentrated in specific states. We've now started to drill down on what variables affect ASC location in specific markets. This should help us better understand the factors influencing ASC growth.

The first question is what geographic unit best approximates an ASC market area, a county, metropolitan statistical area or MSA, or a market defined by patterns of hospital use? We currently have a study underway that uses data on where an ASC's patients live to help define an ASC market area. In the meantime, we have used MSA and counties as proxies for ASC markets and looked at the characteristics of areas with different levels of ASC concentration. Our results from MSA and county analyses were similar so I'll only be presenting the MSA results.

We divided MSAs into quartiles based on the number of ASCs per 1,000 population in each area. We compared MSAs in the lowest quartile of ASC concentration to MSAs in the highest quartile. Areas with the most ASCs tended to have smaller average population size, faster population growth, lower managed-care penetration, higher poverty rate, and more hospital beds and surgeons. There was almost no difference between high and low ASC areas in terms of median income, the share of the population over 65, use of all Medicare services, and beneficiary risk scores.

Some of these results make sense. For example, it's not surprising that ASCs tend to be located in markets with faster population growth, which probably indicates a growing market for health care services, with more surgeons who can do the surgical procedures, and lower managed-care penetration which might indicate looser provider networks.

However, some of these results are puzzling. For example,

we would have expected ASCs to choose markets with higher median incomes and greater Medicare service use, which might indicate stronger demand for surgical services.

We also looked at the relationship between ASC location and the presence of state certificate of need laws that regulate ASC development. In 2002, 61 percent of ASCs were located in the 24 states without these requirements. These states accounted for 57 percent of the U.S. population and 56 percent of beneficiaries, so it doesn't appear that CON laws by themselves play a major role.

For our next steps we plan to use multivariate analyses to isolate the impact of variable while controlling for other factors. We also plan to the look at whether there are common factors that influence the location of ASCs and other specialized entities such as IDTFs and specialty hospitals.

Finally, we intend to examine whether markets with high ASC concentration process are associated with greater overall use of surgical services. This study is part of our specialty hospital workplan which Carol and Julian will be discussing tomorrow.

This concludes my presentation and I look forward to your feedback and discussion.

DR. STOWERS: I just want to make a comment. If you level out for quality and the physician knows the facility and knows that it's going to provide essentially the same service as what is provided in the hospital, I think one thing that explains this growth and that sort of thing that I didn't see discussed in here was the fact that usually the upfront charge to the patients in these facilities is dramatically less than what it is in the hospital. So you may want to get that average charge data.

But even more than that, from the patient's perspective, the copay or amount that -- because it's Part B, or if the patient is a private pay patient or with some insurance is dramatically less. I referred to CAT scan last month that was $2,000 in the hospital, cost a total of $900 in one of these facilities. The patient's responsibility dropped from $1,000 to $1,100 down toe $390. So I just think that part of the growth I know out in the rural community is just the fact that a lot of it is patient driven. They're convenient. They can get it at a more economical cost. As we get a broader part of our population that doesn't have that employee insurance and all the other things that they've had in the past this is becoming more and more attractive as an economical place to get their health care done.

DR. ROWE: I think while the name says diagnostic, some of the procedures that are done in the diagnostic vendors are actually therapeutic and not just diagnostic, such as getting coronary angiogram or an angioplasty. Is that the case?

MR. WINTER: I don't see any claims for angioplasties or stents. When they do cardiac catheterization it's just the angiogram. They bill for two things. They bill for placement of the catheter and the related imaging is just an angiogram. That's what's showing up in the claims.

DR. REISCHAUER: It might be interesting to do a case study of colonoscopy. Here's something that is newly covered, number one. Certainly is pretty far down on the list of the things that

people want to have done, is pretty far up on the list of things that people should have done and aren't having done, are done in outpatient settings and in ASCs, and probably, although I don't know, much more efficiently done in a non-hospital setting, I mean from the standpoint of the individual. It's less of a hurdle and all that. To look at both the amount of this that's going on in these kinds of settings versus hospitals over a period of time and see if we can ferret out something. I don't think you can argue that there's a lot of inappropriate colonoscopy going on. So we just get rid of that issue and try and look at the pure what's left in the market.

MR. HACKBARTH: So this would be a way of testing whether these new types of facilities are increasing access, and attractive?

DR. REISCHAUER: More attractive to individuals, things like that.

MR. WINTER: The last couple of times we've looked at that, at the trends in site of care for different kinds of services, colonoscopy is increasing in ASC essays relative to outpatient department and physician office, but we haven't updated that in about a year and-a-half or two years, so we could look at that again.

DR. REISCHAUER: We can look across metropolitan areas and see if an infusion of ASCs creates greater utilization.

DR. NELSON: A comment and a question. The comment, I understand why these are commingled, these two categories of facilities for the purposes of your research. But if this were to appear in the form of chapters the audiences for it would almost certainly say that ambulatory surgical centers are vastly different from than independent testing facilities. One provides therapeutic services, the other diagnostic and so forth. So after the work is done, if it sees the light of day in publication I would hope that they would be separated in some fashion.

DR. MILLER: This was completely a convenience of organizing some information for the purposes of presentation here. We had a couple things that were responding to questions, couple of things were getting off the ground. Ariel was doing both of them so we just packaged it for -- these things are headed to different homes in the long run.

DR. NELSON: I assumed that that was the case but I wanted reassurance and thank you for that.

The second is that, I wonder the degree to which these facilities has grown is a product of managed-care contracts? Where, for example, my managed-care entity when I or a member of my family needs an imaging service we go to one of these and it's because that's whom they have a contract with, rather than selecting hospital facilities to contract with.

That may not be as much a factor in Medicare+Choice but their existence and growth may be a product of managed-care penetration. I don't know and I don't know that it's worth doing a lot of digging to find out, but if there's an easy way to correlate those two it might be interesting.

MR. WINTER: As we did with the characteristics of ASC

markets we're also going to look at what are the characteristics of markets with lots of IDTFs and few IDTFs, and one of those factors we'll look at is managed-care penetration. So we can try to get at that at least broadly speaking.

MR. MULLER: My question is essentially the same. If they have these costs and convenience attributes, how are private payers incentivizing the use of them, the ASCs, the diagnostic facilities and so forth? That in a sense is a test case because they have clear financial incentives to do so, if in fact this steers patients towards a lower-cost or a higher benefit type of setting. So if there's any evidence that we have that there's clear incentives in that market to drive people in this direction versus the hospital outpatient setting and so forth. That would be useful to see as an example of the questions we're asking.

MR. WINTER: We'll look into that.

MS. ROSENBLATT: I don't know how you get statistically at this issue but Ray and I were just having a side conversation here. There is something different about these ambulatory surgical centers in terms of the ambiance versus a hospital. I really think that -- I'll count myself in. Depending on what I'm having done, I'd rather go to an ambulatory surgical center just because there's a different environment than there is in a hospital. I have a feeling I'm not unique in that.

MR. WINTER: We've recently some site visits to ASCs in the D.C. area, two endoscopy centers and a multispecialty facility and they're very nice. My son recently had surgery at an ASC in Montgomery County and it was also a very positive experience, so I can see the attraction. Maybe not for him.

MS. ROSENBLATT: I've been to one in Beverly Hills where it looked more like a hospital spa.

DR. ROWE: I don't know much about Beverly Hills I'm just a guy from Hartford, Connecticut, but I would say a couple -- while ambulatory surgery centers are attractive and many of them that's because they're new because of this growth. They're different in a number of ways. Often the cost is lower because the workforce is not an organized bargaining unit whereas in hospitals they ordinarily are. That's one of the other differences, not that that should guide our policy one way or the other.

Secondly, there's very little training that goes on in these facilities. There are very few residents in these facilities. Usually when the procedures occur in the hospital outpatient department, the residents are rotating there, et cetera. These are often in remote locations.

I think, thirdly, the patient population is different. Alice is a good example of a healthy, young woman who can go to an ambulatory surgery center. A frail, older Medicare beneficiary with multiple comorbidities is not as well managed always in that kind of an institution, particularly if the procedure carries greater risk of an adverse event because of the condition of the patient.

So before we get irrationally exuberant about these beautiful new spas and/or ASC, I think they play a role. It's okay that there's not much training as long as there's enough training, colonoscopies or whatever it is, for the residents to

get the training that they need to be able to take care of Medicare beneficiaries. They don't need to be there for every case. So they do play an important role, but it's part of the picture and has to be seen as part of the picture.

MR. WINTER: Just to make a note here to Jack, our research on patient mix differences between ASCs and outpatient departments supports what you're saying about the frailer and sicker patients go to outpatient departments.

MS. ROSENBLATT: If I could just make one statement in my defense here before I get connected with Beverly Hills. This is probably another issue that we need to be careful about. I was ill when I went to that Beverly Hills ambulatory surgical center. It was done under doctor's advice and if I had it to do over again I would have done the procedure in a hospital, not at the ambulatory surgical center. So I really do think patients like myself are being sent to the wrong venue at times.

MR. MULLER: Along those lines, some of the states that have more restrictions on things -- there's a reason that they do ophthalmology and those more simple procedures, is literally you have one case that goes sour in one of these settings because somebody went there and there wasn't the appropriate backup, that usually then leads to some kind of regulatory fever to stop their explosion. So I know you don't have as much -- it's kind of hard to -- your variable is more CON and non-CON, and I'm not sure there's any good way of sorting out a variable there that has a little bit more power than just the on-off switch of whether you have CON or not. But sometimes you do see that, that the regulatory climate does change when some more complex case is done and then something happens.

MR. DeBUSK: From a device standpoint, the roles that ambulatory surgery centers play today will be completely different in the future because of the research and development and the dollars that are being spent today on devices and what have you is around the 23-hour stay in the surgery center. A great deal is going on there with that. They're even doing hips at Duke University on an outpatient basis now. So that is going to change.

MR. HACKBARTH: Anybody else?

Okay, thank you very much.